

EXHIBIT 1: MODEL INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C) OR MEDICARE PRESCRIPTION DRUG PLAN (PART D)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to: Signature Advantage 12201 Bluegrass Parkway Louisville, KY 40299

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Signature Advantage at 844-214-8633. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Signature Advantage al 844-214-8633 TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Section 1 – All fields on this page are required (unless marked optional)				
Select the plan you want to join:				
☐ Signature Advantage Plan – \$29.70 per month ☐ Signature Advantage Community – \$29.70 per month				
FIRST name:	LAST name:	[Optional: Middle Initial]:		
Birth date: (MM/DD/YYYY)	Sex:	Phone number	er:	
	☐ Male ☐ Female	()		
Permanent Residence street address (Don't enter a PO Box):				
City:	[Optional: County]:	Sta	ate:	ZIP Code:
Mailing address, if different from your permanent address (PO Box allowed):				
Street address:	City:	Stat		de:
	Your Medicare info	rmation:		
Medicare Number:				
A	Answer these importan	t questions:		
Will you have other prescription drug of	coverage (like VA, TRIC	CARE) in addi	tion to Signatur	re Advantage?
				□ Yes □ No
Name of other coverage:	Member number for thi	s coverage:	Group numbe	er for this coverage
-		_	_	_
Are you a resident in a long-term are facility, such as a nursing home or assisted living facility? Yes No If Yes, please provide facility name Facility Address				
Are you enrolled in your State Medicaid program? Yes No If yes, please provide your Medicaid number				
IMPORTANT: Read and sign below:				

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Signature Advantage, he/she may be paid based on my enrollment in Signature Advantage.

Release of Information: By joining this Medicare health plan, I acknowledge that Signature Advantage will release my information to Medicare and other parties as is necessary for treatment, payment and health care operations. I also acknowledge that Signature Advantage will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Signature Advantage.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Signature Advantage will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in theplan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.

 I understand that when my Signature Advantage coverage begins, I must get all of my medical and prescription drug benefits from Signature Advantage. Benefits and services provided by Signature Advantage and contained in my Signature Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Signature Advantage will pay for benefits or services that are not covered. I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that: This person is authorized under State law to complete this enrollment, and Documentation of this authority is available upon request by Medicare. 		
Signature:	Today's date:	
If you're the authorized representative, sign above and fill		
Name:	Address:	
Phone number:	Relationship to enrollee:	

Section 2 – All fields on this page are optional		
Answering these questions is your choice. You can't be denied coverage because you don't fill them out.		
Select one if you want us to send you information in a language other than English or in an accessible format. Española (Spanish)		
☐ Braille ☐ Large print ☐ Audio CD		
Please contact Signature Advantage at 844-214-8633 if you need information in an accessible format other		
than what's listed above. Our office hours are 8a.m. – 8p.m. 7-days per week from October 1 – March 31		
and 8 a.m. – 8 p.m. April 1 – September 30, excluding major holidays. TTY users can call 711.		
Do you work? Yes No Does your spouse work? Yes No		
List your Primary Care Physician (PCP), clinic, or health center:		
Select if you would like to get the following materials via email.		
Enrollment related communications, such as signed electronic copies of this form.		
E-mail address:		

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Signature Advantage the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't Select a payment option, you will get a bill each month.
Please select a premium payment option:
Get a bill each month
Automatic deduction from your monthly Social Security or Railroad Retirement (RRB)Board Benefit Check
I get monthly benefits from Social Security RRB
(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If social Security RRB does not approve your request for automatic deduction, we will end you a paper bill for your monthly premiums.)
OFFICE USE ONLY:
Name of staff member/agent/broker (if assisted in enrollment):
Plan ID #
Effective Date of Coverage:
ICEP/IEP: AEP: SEP (type): Not Eligible: Other:
Signature Advantage Plan (HMO ISNP) and Signature Advantage Community (HMO ISNP), offered by Signature Advantage, LLC, are a Health Maintenance Organization Special Needs Plan (HMO ISNP) with a Medicare contract. Enrollment in Signature Advantage depends on contract renewal.
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